# United States Department of Labor
# Employees' Compensation Appeals Board

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| **C.S., Appellant** | ) | |
| **and** | ) | **Docket No. 18-0920** |
| | ) | **Issued: September 23, 2019** |
| **DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Reno, NV, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, Esq.*, for the appellant[1]
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On March 29, 2018 appellant, through counsel, filed a timely appeal from a February 5, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that following the February 5, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id.*

## ***ISSUE***

The issue is whether appellant has met her burden of proof to establish that she has greater than five percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

## ***FACTUAL HISTORY***

This case was previously before the Board.[4] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On April 7, 2011 appellant, a 56-year-old purchasing agent, filed a traumatic injury claim (Form CA-1) alleging an injury when she tripped over a telephone cord and fell onto her face while in the performance of duty. OWCP accepted the claim for nasal bone fracture, contusion of her right elbow and forearm, lumbar sprain, displacement of lumbar intervertebral disc without myelopathy, aggravation of degenerative disc disease of the lumbar spine, and right lateral epicondylitis. OWCP paid appellant wage-loss compensation on the supplemental rolls through December 30, 2011.

On May 25, 2016 appellant filed a claim for a schedule award (Form CA-7).

In an April 18, 2016 report, Dr. Kenneth Pitman, a Board-certified anesthesiologist, opined that appellant had reached maximum medical improvement (MMI).

In support of her claim for a schedule award appellant submitted a July 13, 2016 report from Dr. Michael E. Hebrard, a Board-certified physiatrist, who reviewed her history of injury, her medical record and accepted employment-related conditions, his findings on physical examination, and applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] Dr. Hebrard noted that since 2012 she had been using a motorized scooter which was prescribed due to her back injury, that she could not walk one block, and that standing was problematic. On physical examination he noted that appellant's lumbar spine range of motion (ROM) was limited by more than 50 percent and there was mild laxity with ulnar and radial stressing of the right elbow; sensory examination revealed paresthesia in the L4 through S1 dermatome distributions bilaterally with light and sharp touch; deep tendon reflexes were unelicitable in the upper and lower extremities bilaterally; motor strength of the elbow was 4/5 bilaterally for flexion and extension; Jamar testing on the second ring, rapid alternating technique, averaged 18 and 10 on the right and 12, 14, and 12 on the left; good effort was evidenced by blanching of knuckles on each attempt; hip flexion was 4/5 bilaterally; knee extension and flexion were 4/5 bilaterally; a positive sacroiliac (SI) joint compression test bilaterally and a positive Finkelstein test on the right wrist; and that she

[4] Docket No. 13-0624 (issued June 26, 2013).

[5] A.M.A., *Guides* (6th ed. 2009).

demonstrated an antalgic gait on the right. Dr. Hebrard concluded that appellant's conditions had never fully healed from the traumatic injury.[6]

In rating appellant's permanent impairment of her lumbar spine, Dr. Hebrard referenced *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August2009) (*The Guides Newsletter*) and noted that he was rating the right side only, given the corroborating electromyography (EMG) evidence on the right, but not on the left. He found that appellant had a spinal nerve root impairment of L4-5 on the right. Dr. Hebrard opined that appellant had a moderate sensory deficit at L4 which equated to three percent permanent impairment and mild motor deficit which equated to five percent permanent impairment, totaling eight percent impairment for sensory and motor deficits at L4. For the right L5 rating, he found a moderate sensory deficit for three percent permanent impairment, mild motor deficit for five percent permanent impairment, totaling eight percent permanent impairment for sensory and motor deficit at L5. Using the Combined Values Chart on page 604, Dr. Hebrard found 15 percent permanent impairment for the spinal nerve root impairment on the right.

On November 8, 2016 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed the medical evidence of record. He provided an opinion as to permanent impairment of appellant's right upper extremity permanent impairment, and reviewed the rating by Dr. Hebrard of her spinal conditions. Regarding appellant's right elbow, the DMA found that her most impairing diagnosis was collateral ligament injury with instability, occasional, which was a CDX of 1 with a default impairment rating of five percent. He noted that Dr. Hebrard's nine percent impairment rating was not an available choice for any of the impairments on page 399 of the A.M.A., *Guides*. The DMA also noted that Dr. Hebrard observed "mild laxity" of the right elbow with ulnar and lateral stress to the elbow and opined that the presence of laxity did not imply the existence of instability, and in search of the records, he was unable to find documentation of an episode of elbow instability. He indicated concerns with the ratings provided by Dr. Hebrard as he had assigned no grade modifiers for his determination of spinal nerve impairment. Given the lack of detail regarding the determination of spinal nerve impairment to the lower extremity, the DMA recommended a second opinion evaluation to determine appellant's work-related permanent impairment.

OWCP referred appellant to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine the nature and extent of her employment-related permanent impairment. In his March 8, 2017 report, Dr. Swartz noted that he had reviewed a statement of accepted facts (SOAF), the medical record, and performed a physical examination. He noted mild tenderness in the right lateral epicondyle and a negative Cozen's test referable to the right lateral elbow; a negative reverse Cozen's test referable to the right medial epicondyle; range of motion (ROM) testing of the right elbow as compared to the left elbow demonstrated extension 0/0 degrees, flexion 130/130 degrees, pronation 90/90 degrees, and supination 70/70

[6] Utilizing the Elbow Regional Grid, Table 15-4, page 399, of the sixth edition of the A.M.A., *Guides* Dr. Hebrard found that appellant's most impairing diagnosis was a class 1 collateral ligament injury, with recurrent instability and atrophy on clinical examination. He determined a class of diagnosis (CDX) of 1 and assigned a grade modifier of 2 for physical examination (GMPE) due to pain with normal activity and medications to control symptoms. Dr. Hebrard assigned a grade modifier of 2 for functional history (GMFH) due to a 2 centimeter atrophy in the right dominant hand and biceps. No grade modifier was provided for clinical studies (GMCS). Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), Dr. Hebrard calculated that appellant had a net adjustment of (2-1) + (2-1) + (n/a) = 2, equaling a default grade E. Based on these calculations, he concluded that appellant had nine percent permanent impairment of the right elbow.

degrees; and 5/5 strength in both elbows; and no evidence of instability to the right elbow or the left elbow. Dr. Swartz opined that, pursuant to the A.M.A., *Guides* Table 15-4, Elbow Regional Grid, page 399, appellant's most impairing diagnosis was chronic lateral epicondylitis of the right elbow, noting it was relatively mild and symptomatic in colder weather. He found a CDX of 1 with a default impairment rating of one percent. Dr. Swartz assigned a GMFH of 1, with no GMPE or GMCS applicable, and found one percent permanent impairment of the right upper extremity. Examination of her lumbar spine revealed tenderness in the lower lumbar segments from L4-S1, without spasm, although Dr. Swartz reported that she was significantly obese which made discerning spasm difficult; mild tenderness over both SI joints and mild tenderness in both iliolumbar ligament regions; mild tenderness in the right sciatic notch, but not on the left; mild tenderness over both lateral hips; lumbar flexion of 60 degrees, lumbar extension of 10 degrees, lateral flexion of 20 degrees to the right and to the left, and rotation of 40 degrees to the right and to the left; reflexes were absent in the lower extremities; and sensation was intact in both the upper and lower extremities. He determined that appellant had reached MMI on March 8, 2017.

Regarding the lumbar spine, Dr. Swartz opined that appellant's most impairing diagnosis was chronic low back and right lower extremity pain, with February 9, 2016 magnetic resonance imaging (MRI) scan findings of moderate-sized right paramedian disc protrusion with marked right lateral recess stenosis, impinging on the emerging right L4 nerve root, and noting only borderline bilateral foraminal stenosis. He noted EMG findings dated December 18, 2015 of possible right L4-5 radiculopathy versus local superior gluteal neuropathy, a normal neurologic examination in the lower extremities, and normal straight-leg raise testing bilaterally. Dr. Swartz noted, however, that her objective complaints had been consistent in the low back and right lower extremity and that the MRI scan and electrodiagnostic studies correlated with these objective findings. In addition to tenderness in the right sciatic notch the neurological problems appeared to be involving the L3-4 level and the L4 nerve root on the right. Utilizing *The Guides Newsletter*, he found that pursuant to page 6, Table 2, the electrodiagnostic studies supported a five percent lower extremity impairment. Dr. Swartz found a GMFH of one due to mild antalgic gait and use of a cane, a GMCS of one for an EMG study revealing 1+ polyphasic motor unit activity and an indication of fibrillation potentials and a positive shockwave. There was no GMPE provided. Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), he calculated that appellant had a net adjustment of (1-1) + (n/a) + (1-1) = zero, equaling a default grade C. Based on these calculations, Dr. Swartz concluded that appellant had five percent permanent impairment of the right lower extremity related to her accepted lumbar spine conditions.

On April 14, 2017 the DMA reviewed the medical evidence of record, including the second opinion report of Dr. Swartz, and provided updated impairment ratings.[7] Regarding appellant's lumbar condition, the DMA found a CDX of 1 with a default impairment rating of five percent. He assigned a GMFH of 1 and a GMCS of 1 and found GMPE was not applicable. Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), the DMA calculated that appellant had a net adjustment of (1-1) + (n/a) + (1-1) = zero, equaling a default grade C, for five percent permanent impairment of the right lower extremity.

[7] The DMA found that for appellant's right upper extremity that her most impairing diagnosis was epicondylitis (lateral or medial, painful injury, residual symptoms) with a CDX of 1 with a default impairment rating of one percent. He assigned a GMFH of 1 and GMPE of 1, and no GMCS. Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), the DMA calculated that appellant had a net adjustment of (1-1) + (1-1) + (n/a) = zero, equaling a default grade C for one percent permanent impairment of the right upper extremity.

By decision dated May 31, 2017, OWCP granted appellant a schedule award for one percent permanent impairment of the right upper extremity and five percent permanent impairment of the right lower extremity. The award ran for 17.52 weeks for the period March 8 to July 8, 2017.

On June 8, 2017 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Appellant submitted progress reports and procedure notes from June 23 to September 28, 2017 from Dr. Pitman as well as notes from a nurse practitioner.

A telephonic hearing was held before an OWCP hearing representative on November 15, 2017. Appellant provided testimony and the case record was held open for 30 days for the submission of additional evidence.

Appellant subsequently submitted progress reports dated October 26 and December 20, 2017 from Dr. Pitman consisting of diagnostic reports.

By decision dated February 5, 2018, an OWCP hearing representative affirmed the prior schedule award decision with respect to the right lower extremity and remanded the case for further development regarding the right upper extremity based upon the necessity of consideration of a ROM-based impairment rating.[8]

## ***LEGAL PRECEDENT***

The schedule award provision of FECA,[9] and its implementing federal regulations,[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[11] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[12]

[8] FECA Bulletin No. 17-06 (issued May 8, 2017).

[9] *Supra* note 2.

[10] 20 C.F.R. § 10.404. By decision dated February 5, 2018, an OWCP hearing representative remanded appellant's schedule award claim of her right upper extremity for further development as to the extent of her permanent impairment under the ROM method of evaluating permanent impairment. Therefore, the issue of the extent of appellant's right upper extremity schedule award is not presently before the Board. *See* 20 C.F.R. § 501.2(c).

[11] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[12] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[13] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[14] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[15] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[16]

Neither FECA nor its regulations provide for a schedule award for impairment to the back or to the body as a whole.[17] Furthermore, the back is specifically excluded from the definition of organ under FECA.[18] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter* is to be applied.[19]

A claimant has the burden of proof to establish that the condition for which a schedule award is sought is causally related to his or her employment.[20]

## ***ANALYSIS***

The Board finds that appellant has not met her burden of proof to establish that she has greater than five percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

In his July 13, 2016 report, Dr. Hebrard indicated that appellant's lumbar spine ROM was limited by more than 50 percent and provided specific physical examination findings. Referring to *The Guides Newsletter*, he found that appellant had a spinal nerve root impairment of L4-5 on the right. Dr. Hebrard opined that appellant had a moderate sensory deficit at L4 which equated to three percent permanent impairment and mild motor deficit which equated to five percent permanent impairment, totaling eight percent impairment for sensory and motor deficits at L4. For the right L5 rating he found a moderate sensory deficit for three percent permanent impairment, mild motor deficit for five percent permanent impairment, totaling eight percent permanent

[13] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, ICF: A Contemporary Model of Disablement.

[14] *Id*. at 494-531.

[15] *Id*. at 411.

[16] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[17] *See J.L.*, Docket No. 18-1380 (issued May 1, 2019). FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

[18] 5 U.S.C. § 8101(19).

[19] *Supra* note 6 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[20] *See G.S.*, Docket No. 18-0827 (issued May 1, 2019).

impairment for sensory and motor deficit at L5. Using the Combined Values Chart on page 604, he found 15 percent permanent impairment for the spinal nerve root impairment on the right.

Following review by a DMA, OWCP properly referred appellant to Dr. Swartz for a second opinion evaluation to determine the nature and extent of her employment-related permanent impairment. In his March 8, 2017 report, Dr. Swartz provided physical examination findings and determined that appellant had reached MMI on March 8, 2017. Regarding the lumbar spine he utilized *The Guides Newsletter* to find five percent permanent impairment of the right lower extremity due to her spinal nerve impairment pursuant to page 6, Table 2. Dr. Swartz found a GMFH of 1due to mild antalgic gait and use of a cane, a GMCS of 1 for an EMG study revealing 1+ polyphasic motor unit activity and an indication of fibrillation potentials and a positive shockwave. There was no GMPE provided. Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), he calculated that appellant had a net adjustment of (1-1) + (n/a) + (1-1) = zero, equaling a default grade C. Based on these calculations, Dr. Swartz concluded that appellant had five percent permanent impairment of the right lower extremity related to her accepted lumbar spine conditions.

In accordance with its procedures, following the second opinion evaluation, OWCP properly referred the evidence of record to a DMA for review. On April 14, 2017 the DMA reviewed the medical evidence of record, including the March 8, 2017 report of Dr. Swartz, and concluded that the rating provided by Dr. Swartz for the right lower extremity, five percent permanent impairment, was appropriate.

The Board finds that the DMA correctly applied the appropriate tables and grading schemes of *The Guides Newsletter* to Dr. Swartz's physical examination findings. The DMA's calculations were in accord with the rating provided by the second opinion report of Dr. Swartz. Both the DMA and Dr. Swartz noted the lack of a thorough explanation regarding Dr. Hebrard's lower extremity impairment rating, and no additional clarification was received from Dr. Hebrard. There is no medical evidence of record utilizing the appropriate tables of the sixth edition of the A.M.A., *Guides* or *The Guides Newsletter* demonstrating a greater percentage of permanent impairment of the right lower extremity. Accordingly, the Board finds that as appellant has not submitted medical evidence establishing more than five percent permanent impairment of her right lower extremity, she has not met her burden of proof.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

## ***CONCLUSION***

The Board finds that appellant has not met her burden of proof to establish greater than five percent permanent impairment of the right lower extremity, for which she previously received a schedule award.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the February 5, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 23, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board